Archives of Disease in Childhood, 1984, **59**, 865–870

Therapeutic approach to sexual abuse

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SUMMARY An account is given of the development of a treatment project for sexually abused children and their families. We review incidence data which indicate that sexual abuse of children is likely to be a far more frequent problem than has been recognised and cause an appreciable degree of psychological damage. Professional responses to this are confused and treatment facilities limited.

Sexual abuse is seen as an expression of severe relationship problems in the family and therapeutic provision is made, therefore, not only for the abused child but for other members of the family (including both parents). The method adopted is to offer group therapy to the child, mother, and father and regular family meetings with professionals in the community, concerned with care and protection of children.

Clinical data on the first 56 children treated are discussed and our approach to treatment is evaluated.

Although incest and the sexual abuse of children within the family are universal taboos, they occur far more frequently than is acknowledged. Until recently, however, it has also been taboo to talk about the issue and to deal with it. As this taboo is often shared by the family and professionals alike, the problem has remained widely unrecognised. One of the difficulties in recognition is distinguishing between what is appropriate erotic physical contact between adult and child and what is abusive sexual behaviour.[1] There is also widespread doubt about how far sexual abuse is damaging to the child.

Incest is defined legally as intercourse between biological family members, but we use the term to describe any form of long standing sexual abuse between any adult in a parental role and a child, within the family context. Kempe and Kempe[2] have provided a helpful and widely accepted definition of sexual abuse of children; 'child sexual abuse is the involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, to which they are unable to give informed consent and which violate the social taboos of family roles'. A study of professional recognition of sexual abuse of children in the United Kingdom[3] showed awareness to be at a stage similar to the acknowledgement of physical child abuse some 20 years ago. There is a lack of professional skill and readiness to diagnose and deal with sexual abuse of children as well as a lack of treatment facilities. The sense of helplessness among professionals means that families do not know where to seek help so that incest and sexual abuse within the family come to light in only a proportion of cases. In addition, the threat of criminal proceedings against the perpetrators, who are most frequently the child's father or step father, prevents disclosure.[3 4] Family breakup is frequently enforced by imprisonment of fathers, and often enough the child is removed into care.

Incidence

As yet hard data about the prevalence and incidence of sexual abuse and incest are scarce. A study of 796 American college students[5] found, however, that 19% of the woman and nine per cent of the men had had some experience of sexual abuse as children, and a recent study[6] using more rigid criteria describes 38% of women reporting at least one experience before the age of 18 and 28 per cent before the age of 14 years. By contrast, in the United Kingdom[3] only three in 1000 children who experienced sexual abuse at some stage in their childhood would be likely to come to professional notice. A recent self report survey in a United Kingdom teenage magazine[7] drew 1500 positive responses, a minimum of one per cent of the readership. If this were representative it would mean at

least 5000 new cases of incest and child sexual abuse would present every year.

The United Kingdom survey[3] showed that the most frequent perpetrators of abuse were fathers and step fathers. Forty three per cent of perpetrators were family members and 31 per cent trusted family acquaintances. Only 26 per cent of the perpetrators were strangers. Thus sexual abuse of children is far less a problem of rape or seduction by strangers in the street—like physical abuse, it is far more likely to occur as a symptom within the family context.

Increasing awareness of the extent and the potential damage of long term sexual abuse[8] led us to initiate the first British project for the treatment of sexual abuse of children in the Department of Psychological Medicine at this hospital. The availability of a treatment programme has increased the number of referrals for child psychiatric help for children and families. The development of professional skills and awareness in combination with the offer of practical help may also influence the rate of discovery. This is illustrated by the referral of 56 cases during the first 18 months of the project and 100 cases within the first two years.

Symptoms and presentation

Children who are sexually abused present with different symptoms at different ages and stages of their development (Table 1). Physical and behavioural symptoms may predominate in early childhood and psychosomatic and behavioural disturbances in the prepubertal age group. In adolescence there may be behavioural symptoms, psychosomatic symptoms, and psychiatric symptoms. There are, however, very few symptoms apart from venereal infections which lead to a clear conclusion of sexual abuse. Any of these symptoms may be associated with sexual abuse and it is important for the clinician to include this in the differential diagnosis of a wide range of symptoms.

The following clinical example illustrates the harm which can be done to a child where a probable diagnosis of child sexual abuse is not only unrecognised, but is actively dismissed by the general practitioner.

Two of the six adolescent girls in the first girls group in the project had previously been admitted to hospital for suicidal attempts which had finally led to the disclosure of the incest. In the first case, a girl of 14 had been sexually abused by her step father since the age of 7 years. Abuse had started when her mother was pregnant with her third child. Although the girl had tried to tell her mother, her mother, instead of believing her, went to their general practitioner for advice. He labelled the child as showing signs of jealousy. When mother reported the child's allegations and the doctor's diagnosis to the step father, the girl was physically punished by him for lying. The child did not dare repeat the allegations, and the abuse, which included sexual intercourse, continued until she reached adolescence when she tried to commit suicide. In the second case of attempted suicide, the girl tried to find help when the abuse started at the age of 8 years. In her case, the child's report was labelled as 'a child's fantasy' by the doctor.

Table 1 *Predominant symptoms and presentations of sexual abuse in children*

	Early childhood	*Prepubertal*	*Adolescence*
Physical	Venereal disease* Genital and rectal itching and soreness* Unexplained bleeding and discharges Recurrent urinary tract infections	Venereal disease* Genital and rectal itching and soreness* Unexplained bleeding and discharges Recurrent urinary tract infections	Venereal disease* Genital and rectal itching and soreness* Unexplained bleeding and discharges Unexplained pregnancy
Psychosomatic	Onset wetting, day or night Sleeping and eating disturbances	Recurrent abdominal pains Headaches, sleeping and appetite disorders	
Behavioural	Inappropriate sexual play* Hinting at sexual activities	Sexually provocative behaviour Social and withdrawal Restless and aimless Inexplicable school failure Poor trust and secretiveness	Promiscuous behaviour Drug use Running away
Psychiatric symptom			Self mutilation* Suicidal attempts* Hysterical attacks, fits, and faints

*Most important or relevant symptoms.

Therapeutic approach to sexual abuse of children

The United Kingdom survey[3] showed that sexual abuse in children is overwhelmingly dealt with either by denial or, when it does come to light, in a punitive fashion. Prosecution of perpetrators is the major intervention, and if care proceedings follow this leads to a danger of double victimisation of the child. Therapeutic input is rare. For instance, in only 11% of cases in the survey was a referral made to a child psychiatrist.

In planning a project on sexual abuse of children we based our approach on the following presuppositions:

(1) Like physical abuse of children, sexual abuse in most cases is an expression of severe relationship problems in the family and may lead to physical and psychological damage of the child. The damaging aspect of long standing sexual abuse is not only the child's negative experience of being forced into compliance with the abuse, but also that the abuse often takes place as part of an otherwise caring and trusting parental relationship. Despite the negative aspects, the relationship may be intense and include the experience of positive sexual sensations. These are all ingredients for confusion and difficulty in future sexual relationships and a high risk of a reduced ability to be a partner and a parent.[8]

(2) The removal of a child from the family without therapeutic help often means an escalation of some aspects of the original traumatic experience. The child not only loses her siblings, her friends, and her social environment at a period of crisis, but she often experiences foster and residential placements as punishment and feels guilty and responsible for the abuse as well. She may be blamed openly by her parents.

(3) Imprisonment of perpetrators without therapeutic input leads to a danger of repeating the abuse either on returning to the family or by abusing a child in a newly created family.

(4) The quality of the relationship between mothers and daughters is one of the most important risk factors accounting for child sexual abuse in the family.[7 10] The presence of an emotionally distant or untrusting mother-child-relationship is an important aspect of the family which may contribute to and maintain a sexually abusive relationship.

(5) Although we are describing our approach to understanding incest between fathers and daughters, the processes are similar whether the child is a boy or girl.

Family patterns and family approaches to sexual abuse of children

The motivation towards the sexual abuse of children is rooted in the experiences of the perpetrators. Regressed and fixated individual psychopathology is described.[11] Individual psychopathology, although helpful, is not enough to explain its occurrence and its continuation. The sexual abuse itself seems to have the function of either avoiding sexual conflicts in the marriage, or keeping open sexual conflicts in the marriage at a level which avoids the break up of the family.[12] Instead of resolving sexual conflict within the marriage, dealing with sexual dissatisfactions by seeking help, or avoiding them through extramarital relationships or divorce, fathers turn to the children instead. Although on the surface some fathers seem to dominate and control their families, we have found they are, in fact, not strong and independent but immature and emotionally weak. They tend to be dependent on their wives and to turn to them as protective figures. The inability to separate or to be individual keeps fathers in the family and influences them to turn towards the child.

The mothers fit into the interlocking marital pattern by taking on the role of an emotional caretaker to their husbands. A punitive attitude towards sexuality ensures that sexual conflict is not resolved. In addition, the distance between mothers and daughters means that mothers are insensitive to their daughter's emotional needs or do not believe their children when they try to confide in their mothers and turn to them for help.

This has the double effect of reinforcing a non-protective or even openly hostile relationship between mother and daughter, which may make the daughter turn to the father for emotional parenting. The child is then even more vulnerable and liable to comply with paternal sexual demands.[12]

Aims of therapy

Disclosure of sexual abuse of children in the family leads to an intense crisis for all members. Therapeutic work has to include both the child and the child's family. Work with the family seems indicated both to free the child emotionally, as a precondition for any treatment in her own right, and to prevent the perpetrator offending again. In all cases where parents dropped out of our project, therapy was also interrupted for the child.

The aims of family work are thus:[13]

(1) For the father (perpetrator) to take sole responsibility for the sexual act.

(2) For both parents to take parental responsibility for the emotional care and well being of the daughter.

(3) To work on the mother-daughter relationship

to enable mother to become a more central emotionally caring parent for the child.

(4) To deal with the sexual and emotional conflicts in the marriage which had allowed a pseudomarriage between father and daughter to develop.

(5) To deal with the special relationship that exists between fathers and daughters in order to assist the girl's future ability to relate appropriately to men in her life.

Setting for treatment

The child sexual abuse project at this hospital currently involves child psychiatrists and social workers. The advantage of carrying out treatment in a medical, and particularly a psychiatric, setting lies in the fact that there are no primary statutory obligations towards the child or the parents. This enables the team to organise an overall therapeutic intervention for the child and for the family within a framework of legal and statutory procedures. We would emphasise that a therapeutic approach does not exclude legal measures or the intervention of statutory agencies. On the contrary, experience with our project, as well as American and Dutch examples,[9 14] shows that successful therapeutic programmes often have to be supported by statutory procedures. In a primary therapeutic approach, police action and prosecution may be necessary, but principally as ways of facilitating therapeutic intervention rather than as an end in themselves.[9] For instance a probation order, a suspended prison sentence, or even a period in prison should be no bar to a therapeutic approach. We have been gratified at the response of some prison authorities in the United Kingdom; at their willingness to cooperate and allow family meetings in prison or perpetrators to be given leave to come to the hospital for treatment sessions.

Any intervention in sexual abuse of children has to centre on help for the child as victim. Helping the child, however, may mean having to help the perpetrator and the family. We find it essential to convene a family meeting at the outset of the work to spell out the aims of therapy as outlined previously. In combination with family sessions we offer groups. Group treatment for the children is preferred to individual work because individual therapy can be experienced as a repetition of the highly secret and private one to one abusive situation which has already traumatised the child. Groups give children the opportunity to see that there are other children with the same experience. We have divided the groups according to sex and age. At the present time we have groups for girls between the ages of 6 and 9, 9 and 12, and 13 and 16 years; an adolescent boys group; and a mothers and a perpetrators group.

Table 2 *Ages of onset and referral to the child sexual abuse project*

	Age group (years)			
	0–5	*6–10*	*11–15*	*16+*
Presentation to project (n=56)	8 (15%)	10 (17%)	31 (56%)	7 (12%)
Age of onset of abuse (n=53)	15 (28%)	24 (45%)	13 (25%)	1 (2%)

*Unknown in 3 cases.

Table 3 *Duration of sexual abuse in children*

1 incident—6 months	*6–12 months*	*2–4 years*	*5–7 years*	*8+years*
10	7	24	6	5

Data

In the first 18 months, 56 cases were referred to us. These were cases where sexual abuse had been diagnosed as having occurred, and the principal referral agencies were social services departments, other child psychiatrists, and a few general practitioners concerned about the child care implications of the abuse and the psychiatric needs of the children and their families. It was known that a treatment project was being set up and referral agencies hoped assistance, in terms of management and specific help for the children and families, could be offered to the professionals involved.

The 56 children came from 44 families. Forty six of the referred children were girls, 10 were boys. The age range varied from 4 months to 19 years, but Table 2 shows that most came from the 11 to 15 year group (31 cases) followed by the 6 to 10 year group (10 cases). It should be noted that eight children were under the age of 5 years. The ages at which abuse had started ranged from 3 months to 14 years, but by contrast with the age of referral, the largest number (25 children) were in the age group 6 to 10 years and the second largest group was aged between 0 and 5 years. The discrepancy between the age of onset of abuse and the age of referral points to the duration of abuse (Table 3) which in 24 children lasted between two and four years, and in

11 was for more than five years. The duration of abuse itself varied in the whole group between one incident to 11 years.

Most cases had been reported to the police and social services departments before referral. The largest group of perpetrators were fathers (21 cases) with stepfathers implicated in 16 cases. The perpetrators had been convicted in 29 cases; 20 had prison sentences ranging between 4 months and 8 years (average 3 years). Four perpetrators were on probation orders; in six cases the perpetrators were awaiting trial, and in 19 cases no legal action had been taken. In most cases some form of child care action, whether care proceedings or wardship, had been taken.

Discussion

The data from our project reflect the view that child sexual abuse is mainly a problem within the family context. Only six of the 56 perpetrators were not related to the child or in loco parentis, and even these six were known to or close friends of the families. There was only one case of sexual abuse by a stranger. This finding is important in the light of publicity and the weight given to sexual assaults against children by strangers, while the vastly greater number of children who suffer long term sexual abuse in their own family context is still given little attention. We must emphasise that victimisation from sexual abuse starts early on, even in babyhood with the highest incidence in our clinical sample before puberty.

At present, discovery and referral, even of symptomatic children, happens typically in puberty when the children start to rebel and when their personality development has reached a point where they can find help outside the family.

The data presented from the project are only a beginning. We do not yet know whether the referred children are representative of the most disturbed groups of victims of child sexual abuse. We do not yet know for certain how damaging sexual abuse is in general, although recent data suggest disturbances in a number of areas.[15] Nor do we know what protects the child from developing psychiatric symptoms in the long term or which factors aggravate individual disturbance. The increasing referral rate suggests that there is indeed a need for therapeutic services to be provided. At the very least there is a considerable subgroup within the group of child victims of sexual abuse who do become disturbed and need help through appropriate therapy.

The family and group work with the initial groups of children seem to have achieved an increase in self assertiveness and self esteem in the children. They have an increased ability to make decisions, improved peer relationships, and, for most, relief from presenting symptoms. The project is still in its early stages, but already some families have been rehabilitated. Some parents have decided to divorce and some children have decided that they do not wish to live with their families. For some children, plans have had to be made for alternative care because of failure to rehabilitate.

In sexual abuse in the family, special attention has to be drawn to working with the other professionals involved.[9] One of the main functions of the project is to provide consultation and teaching to medical and other professionals working with sexually abused children in the hospital and in the community. We would also wish to alert general practitioners and other professionals to include child sexual abuse in their differential diagnosis when unexplained symptoms occur in the context of the family patterns we have described.

We thank Marianne Tranter, Dr Eileen Vizard, Dr Danya Glaser, and Dr Flora Botica for beginning and maintaining the impetus of the project. We also would like to acknowledge the support of the Joint Research Board of the Hospitals for Sick Children, Great Ormond Street, and the Leverhulme Trust.

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Received 16 May 1984